CERT Fact Sheet

Comprehensive Error Rate Testing Program

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Background

The Centers for Medicare & Medicaid Services (CMS) uses the Comprehensive Error Rate Testing (CERT) program to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. Under this program, over 140,000 randomly-selected claims are reviewed each year. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational and interventional programs.

Methodology

Currently, CMS calculates a national paid claims error rate, a contractor specific error rate, services processed error rate (which measures whether the Medicare contractor made appropriate payment decisions on claims) and a **provider compliance error rate** (which measures how well providers prepared claims for submission).

The CMS methodology includes:

- Randomly selecting a sample of claims submitted in a specific calendar year;
- Requesting medical records from providers who submitted the claims;
- Reviewing the claims and medical records to see if the claims complied with the Medicare coverage, coding, and billing rules; and
- Treating the claims as errors and sending the providers overpayment letters when:
  - **providers fail to submit the requested documentation,**
  - **providers submit insufficient documentation, or**
  - **the submitted medical record indicates that the service was not medically necessary, incorrectly coded, or was not in compliance with some other Medicare coverage or billing rule.**

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The CERT Request

The request, with the official CMS logo, will contain the following:

- Claim Attachment Cover Sheet
- List of the medical documentation requested
- Claims attachment Pull list
- Instructions on how to mail or fax information

Note:
We are not authorized to reimburse providers/suppliers for the cost of duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT Documentation Office

What You Need to Do

- Provide requested information.

During a CERT review, you may be asked to provide more information related to a claim you submitted, such as medical records or certificates of medical necessity, so that the CERT review contractor can verify that billing was proper. Be assured that forwarding specifically requested records to the designated CERT contractor does not violate privacy provisions under the Health Insurance Portability and Accountability (HIPAA) law.

- Respond Promptly.

If you receive a letter from CMS regarding a CERT request for medical documentation, you should **respond promptly** by submitting the requested supporting documentation within the time frame outlined in the request. **Physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.**

- Keep your enrollment information current.

It is vitally important for providers to keep enrollment information current. When providers change mailing address, phone numbers, practice location, etc., it is important to keep your Medicare contractor informed within 90 days of the change. Correct address information will help ensure that CERT documentation requests are received and will allow time for your response.

Important Information

If you fail to submit the requested information in a timely fashion, an "error" is registered against both the Medicare contractor (your Medicare Carrier or Fiscal Intermediary) and you, as the Medicare provider. (At this point, the CERT review contractor has no choice but to register the claim submission as “erroneous” because there is insufficient supporting documentation to determine otherwise.) These errors have a corresponding negative impact on the other error rates that are calculated under the CERT program.

Identification of Over Utilized Codes Is Now Available

The list of over utilized codes is now available at www.cms.hhs.gov/cert

Instructions for Submitting Requested Medical Records Documentation

The requested documentation is due as soon as possible after receipt of the initial request. If the requested information is not received within 90 days, CERT operations must assume that the services were not rendered. As noted above, this is then registered as an error against you, the Medicare provider, as well as against your Medicare Carrier or Fiscal Intermediary.

Be sure that your medical records department places a high priority on responding to requests.

Please adhere to the following directions when faxing:

- Send the specific documents listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/Documentation Pull List.
- Place the bar coded cover sheet in front of the medical records/documentation being submitted for review.
- Make sure all pages are complete, legible, and include both sides where applicable.

The preferred method for receipt of medical records/documentation is via FAX

Please adhere to the following directions if you are mailing the requested documentation:

- Send the specific records listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/Documentation Pull List.
- Photocopy each record. Make sure all copies are complete, legible and include both sides of each page.
- Place the bar coded cover sheet in front of the medical records/documentation being submitted for review.

For additional information, please visit the CERT website at www.CERTprovider.org

Medical Record Legibility

The CDC scans all medical records, and posts the images in a central image repository. Scanners ***Do Not*** improve the quality of documents. Faxes of faxes generally reduce the quality of the imaged document.

Providers please remember if you can not read the document, neither can we.